VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

January 5, 2017

Mr. David Anderson, Manager
Maple Hill Residential Care Home
26 Union Street
Waterbury, VT 05676-1303

Dear Mr. Anderson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on December 7, 2016. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

DEC 28 2016

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0154	A. BUILDING: _____ B. WING _____	12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILL RESIDENTIAL CARE HOME	26 UNION STREET WATERBURY, VT 05676

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite re-licensing survey was completed by the Division of Licensing and Protection on 12/7/16. Based on information gathered, the following regulatory violations were identified:	R100		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that a resident assessment was accurate and updated with the current status for 1 of 3 residents sampled (Resident #1). Findings include: Resident # 1 was admitted to the home on 4/1/16. The initial resident assessment was completed at that time and did not have information regarding the Advanced Directives and the Durable Power of Attorney (DPOA) for Healthcare (HC) included. On the assessment completed on 10/14/16, after the resident had been hospitalized, it still did not have the Advanced Directive DPOA-HC information added. The Advanced Directives were present in the resident's medical record, and named the health care DPOA. Also there was no information regarding the hospital stay on the	R136	Accurate + Updated Assessments 12/8/16 A review of resident #1's record was completed and the assessment was updated on 12/8/16 to include Advanced Directives, DPOA and hospitalizations. In the future all assessments will be reviewed in their entirety to assure information is complete to the best of our knowledge.	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PRDVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/22/16

R136 - R266 POC's accepted 1/5/17 JHosmer RN/PMC

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R136	Continued From page 1 10/14/16 readmission assessment. On 12/2/16, another assessment was completed for a significant change in status of the resident, and this assessment did not contain the information regarding the Advanced Directives, and did not indicate that the resident had been hospitalized multiple times since being admitted to the home, most recently from 10/24- 10/28/16. Per interview on 12/7/16 at 12:35 PM, the Registered Nurse at the home confirmed that the assessment was not accurate for the hospitalizations or for the presence of Advanced Directives for Resident #1.	R136		
R188 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	R188	12/8/16 Current Photograph for MAR A photograph of the recently admitted resident #3 was printed and placed in the MAR on 12/8/16. In the future management will ensure new residents photos are posted as soon as possible.	

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R188	Continued From page 2 interview, 1 of 3 residents in the applicable sample did not have a recent photograph on record at the facility. Findings include: During record review on 12/7/16, 1 of 3 residents (Resident #3) lacked evidence of a recent photograph. This resident had been admitted on 11/4/16 and did have other required elements of the record on file. Photographs of other residents reviewed were available in the Medication Administration Record. The lack of photograph for Resident #3 was confirmed by the administrator on 12/7/16 at 1:15 PM.	R188		
R266 SS=D	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to maintain a safe physical environment in two areas. Findings include: 1. During the environmental tour of the home, the surveyor experienced a sudden change of floor surface near room 8 on the first floor. This area appeared to be a threshold-like riser under the carpeting. This was not clearly marked to alert residents or the public to the change in footing. Other such areas in the home were clearly accentuated by colorful tape. The resident residing in room 8 (Resident #2) was found	R266	Floor Surface Change Indicator 12/7/16 Tape which had indicated a change in floor surface had come up. Tape was replaced on 12/7/16 during the survey when it was found to need replacing. Staff and management will continue to conduct regular checks of missing warning tapes needing replacement.	

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R266	Continued From page 3 during record review to be at high risk for falls due to unsteady gait. 2. During the environmental tour of the home, the surveyor noted a sharp metal edge on the uncovered end of a baseboard heat unit. This potentially unsafe sharp edge was at ankle level, at a corner, near the entrance to the elevator, thereby in an area frequently used by those residents residing on the second floor. The two potentially unsafe areas noted were observed and confirmed by the administrator on 12/7/16 at 11:10 AM.	R266	Baseboard Edge A cover to the base-board edge was obtained and baseboard was repaired on 12/8/16. All edges are now covered to ensure resident safety Regular checks of the buildings physical plant will be performed to ensure safety.	12/8/16